Luton Health and Social Care System Five Year Strategy

2014-15 to 2018-19

Draft V2.2 May 16th 2014

Contents

1. Context of Plan

National Context

National Planning Guidance requires that individual units of planning develop a five year system strategy 2014/15 to 2018/19 with key deliverables for the first two of those years articulated via:

- ✓ A CCG Operating Plan
- ✓ A CCG Financial Plan
- ✓ A Better Care Fund Plan
- ✓ Individual Provider Plans
- ✓ An NHS England Area Team Direct Commissioning Plan

This Five year strategy represents the Luton Health and Social Care Systems approach to delivering improved outcomes for local people via a sustainable, joined up , collaborative system.

The need for a cohesive system planning programme is essential to meet the sustainability issues posed by the imbalance between rising demand and supply pressures and our unit of planning (Luton CCG, Luton Borough Council, Luton and Dunstable Hospital, Cambridgeshire Community Services, South Essex Partnership Trust and the Luton Health and Wellbeing Board) will publish its draft five year strategy to deliver a Healthier Luton through a sustainable health and social care system in early April 2014.

Local Planning Context

The diagram on the *next page* shows how local plans fit together to support the Luton Health and Wellbeing Strategy. The Health and Wellbeing Strategy makes a number of commissioning recommendations based on a in depth analysis of local needs based on the local JSNA[1] and highlights three major outcome goals:

Health and Wellbeing Goal 1. EVERY CHILD AND YOUNG PERSON HAS A HEALTHY START IN LIFE

Health and Wellbeing Goal 2. REDUCED HEALTH INEQUALITIES IN LUTON

Health and Wellbeing Goal 3. HEALTHIER AND MORE INDEPENDENT ADULTS AND OLDER PEOPLE

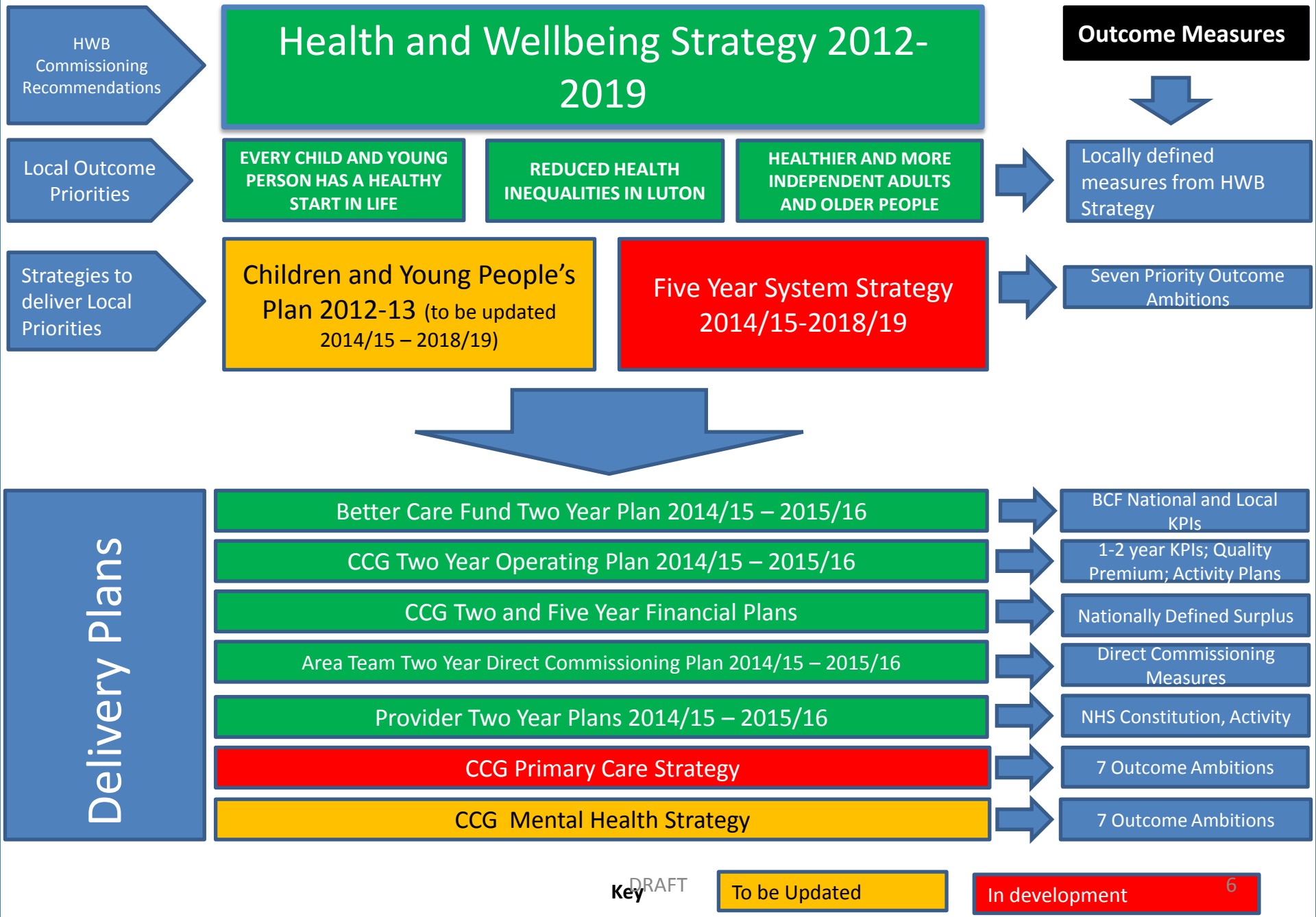
The Children and Young People's Plan articulates how Goal 1 and elements of Goal 2 are being addressed. The System Five Year Strategy with its focus on adults will articulate plans to address Goal 3 and elements of Goal 2.

This Five Year System Strategy has been developed by the **Luton Unit of Planning** which is made up of the following partners:

- Luton Health and Wellbeing Board
- Luton CCG
- Luton Borough Council
- Luton and Dunstable Hospital Foundation Trust
- NHS England Area Team (South Midlands and Hertfordshire)
- South Essex Partnership Trust
- Cambridgeshire Community Services

1 JSNA 2011 and JSNA Core Dataset
http://www.luton.gov.uk/Community_and_living/Luton%20observatory%20census%20statistics%20and%20mapping/Pages/Joint%20Strategic%20Needs%20Assessment%20-%20JSNA.aspx

The Relationship Between the Health and Wellbeing Strategy and Current Plans in development



Local Need

Luton's Population and Health Profile at a glance[1]

- Population 204,000
- BME equals 55% of the population and 66% of school children
- High levels of deprivation – 12,000 children live in poverty. Life expectancy lower than England average
- Life expectancy gap for most deprived areas is 8.9 years for men, 6.4 years for women
- 23.2% of Year 6 children are obese, worse than the England average. Breast feeding and smoking in pregnancy worse than England. Teenage pregnancy and alcohol specific hospital stays among the under 18s are better than the England average.
- Infant mortality is above the England average
- Low rates of adult physical activity and high levels of adult obesity
- CVD mortality worse than England
- Dementia in over 65's to increase by 10% between 2012 and 2016

[1]Based on JSNA 2011 and JSNA Core Dataset
http://www.luton.gov.uk/Community_and_living/Luton%20observatory%20census%20statistics%20and%20mapping/Pages/Joint%20Strategic%20Needs%20Assessment%20-%20JSNA.aspx

Local Views

The Luton system has undertaken an extensive programme of patient and public engagement in order to seek inputs to improving the health of the local population. This has included:

- Patient Reference Groups / Practice Patient Participation Groups
- Deliberative events
- Citizen surveys
- CCG Public launch event
- Is A&E for me? Marketing campaign
- Social media
- Neighbourhood Governance Programme
- "The Big Conversation" engagement programme related to the reconfiguration of mental health and community services

There are a number of themes that have emerged repeatedly:

1. Communication needs to be improved directly with patients/carers and between organisations that are having interactions with patients/carers.
2. Better access to primary care – GPs
3. Quicker referrals onto hospitals/other specialists
4. Accessing all the communities that live in Luton and adapting services to the needs of those communities; both in terms of ethnicity and communities of health.

The key themes have informed the planning and delivery of our major transformational programmes

Local Opportunities

In addition to the JSNA. we have utilised a variety of resources to understand both the challenges and potential opportunities facing us as a system. These resources include the Outcomes and Benchmarking Support Pack[1], Commissioning for Value Insight Pack[2] and the "Anytown" model[3] developed by NHS England.

For example the table below is based on our review of the Commissioning for Value Insight Pack which identifies opportunities for both quality and financial improvements based on a comparison of local performance with similar areas in England.

Commissioning for Value Insight Pack	Quality Opportunity	Value Opportunity
Cardiovascular Disease	✓	✓
Endocrine / Metabolic Disorders	✓	
Genitourinary	✓	✓
Respiratory	✓	✓
Cancer	✓	✓
Gastrointestinal		✓

Opportunities identified in the Anytown Suburban Module
Case management and coordinated care
Palliative Care – Consultant – led community services
24-hour asthma services for children and young people
Mental Health Service user network
Reducing elective caesarian sections
Electronic palliative care coordination systems (EPaCCS)
Hyper Acute Stroke provision
GP Tele-consultation

1 http://www.england.nhs.uk/wp-content/uploads/2014/02/LApack_E06000032-luton.pdf
2 http://www.england.nhs.uk/wp-content/uploads/2013/11/CfV-luton2.pdf
3 http://www.england.nhs.uk/wp-content/uploads/2014/01/at-suburban-rep.pptx

2. System Vision

Development of a System Vision

As part of Luton's Better Together Integration programme, system leaders contributed to the development of a system vision by participating in a Leadership Summit which took place on December 13th 2013. The purpose of the Leadership Summit was for health and care organisations in Luton to share priorities over the next 2-5 years and to consider how we can collectively lead the whole care and health sector to meet integration challenges over the same period.

The group was tasked with articulating what the Health and Social Care System will look like in 2019 and the outcomes of those deliberations are summarised in this section.

Leaders from the following organisations were represented at the Summit: Luton and Dunstable Hospital, Luton Borough Council, East of England Ambulance Services Trust and Luton CCG.

Our System Vision and Principles

In 2019 Luton residents will benefit from integrated health and care that has four elements: a person centred approach enabled by a focus on **PREVENTION** that helps people to keep themselves well; a shared **PERSONAL PLAN** for patients and service users; **BETTER USE OF SHARED EVIDENCE AND DATA**; **A MULTI-DISCIPLINARY, MULTI-PROFESSIONAL TEAM APPROACH** to service delivery built on Four GP clusters in the town. We will work in partnership with patients, their carers, providers and other partners to deliver a high quality and cost effective health and social care system to the people of Luton, empowering them to lead healthy and independent lives.

Principles

Integration and collaboration
Service Innovation
Services around the patient
Safeguarding the vulnerable
Early intervention
Value for money
Citizen engagement
Quality and Safety

How will the system be different in 2019? Summary

A focus on Prevention

- Delivering a wellness programme rather than a focus on treating illness
- Early intervention driving improved outcomes and reduced need for specialist intervention

A Personal Plan

- An e-plan that is personalised and can be shared across the system
- Care co-ordinated by the GP

One Multidisciplinary Team

- Multi-disciplinary teams that will include social workers, district nurses, hospital at home nurses, hospital consultants and home help
- Planning around the person will take account of both physical and mental health needs and mental health professionals will be an integral part of the multi-disciplinary team.

Using the Evidence Well

- Accurately predicting risk of a crisis and putting in place appropriate services to prevent hospital admission
- Putting the right services in place appropriate to the evidence

How will the system be different in 2019? Key Elements

Prevention

- Balance towards early intervention and prevention
- People understand how to keep well and do it
- Realistic understanding and taking ownership of peoples barriers to health issues

Personal Plan

- Assessment for complex needs within good time
- Key Coordinator worker
- Fewer professionals- better sharing info
- Single assessment and plan across organisations
- Existence of a personal plan- person feels able to change/develop/reassess their plan.
- People feeling in control and confident of "their" plan supported by professionals
- A key contact – someone to trust/get to know. Someone to help and support the plan to be delivered
- New roles- carers initiative across health, social care, voluntary sector etc

Multi-Disciplinary Team

- **New Roles- Carers, Social Care, Voluntary Sector etc**
- **Community based care services- Health, Social, Voluntary all together.**
- **Single point of contact for patients**
- **Health/well being/social prescription- all equally important**
- **Services aren't hidden away or discreet**
- **Mental health services integrated within every service**
- **Early customer access to 'knowledge'**
- **Points of Access- Hospital, Shopping Centre, Police Station, Town Centre**
- **Care and support is no longer buildings based**
- **People can access universal services**
- **Caring community**

Using the Evidence Well

- **System is better at predicting crisis and has put appropriate timely services around them**
- **Appropriate interflow between providers; information/physical experience**
- **Use data to deliver and organise services in different communities**
- **IT systems aligned**

2. System Vision

Our system vision embraces the six characteristics of a high quality and sustainable system[1]

Patient and Citizen Involvement

The system is signed up to the Luton Community Involvement Strategy which is fully embedded in the Health and Wellbeing Strategy and this Five Year Strategy.

Wider Primary Care provided at scale

The need for high quality consistent primary care is a key commissioning recommendation in the Health and Wellbeing Strategy. The CCG is currently developing a specific strategy for primary care in partnership with the Area Team with a focus on increasing the range of services available, driving a reduction in variation, improving access, driving clinical leadership, workforce development and training, commissioning of enhanced services, estates, informatics and IT

A modern model of integrated care

The Luton system has commenced delivery of its "Better Together" Programme to drive the delivery of joined up care based around personal needs to create a shift towards prevention, early intervention and treatment at home with reduced reliance on specialist care.

Access to the Highest Quality Urgent Care

An urgent care system working group has been in place for a significant period of time in Luton driving a collaborative approach to ensuring that unscheduled care is deliver through the most appropriate routes

A Step Change in the Productivity of Elective Care

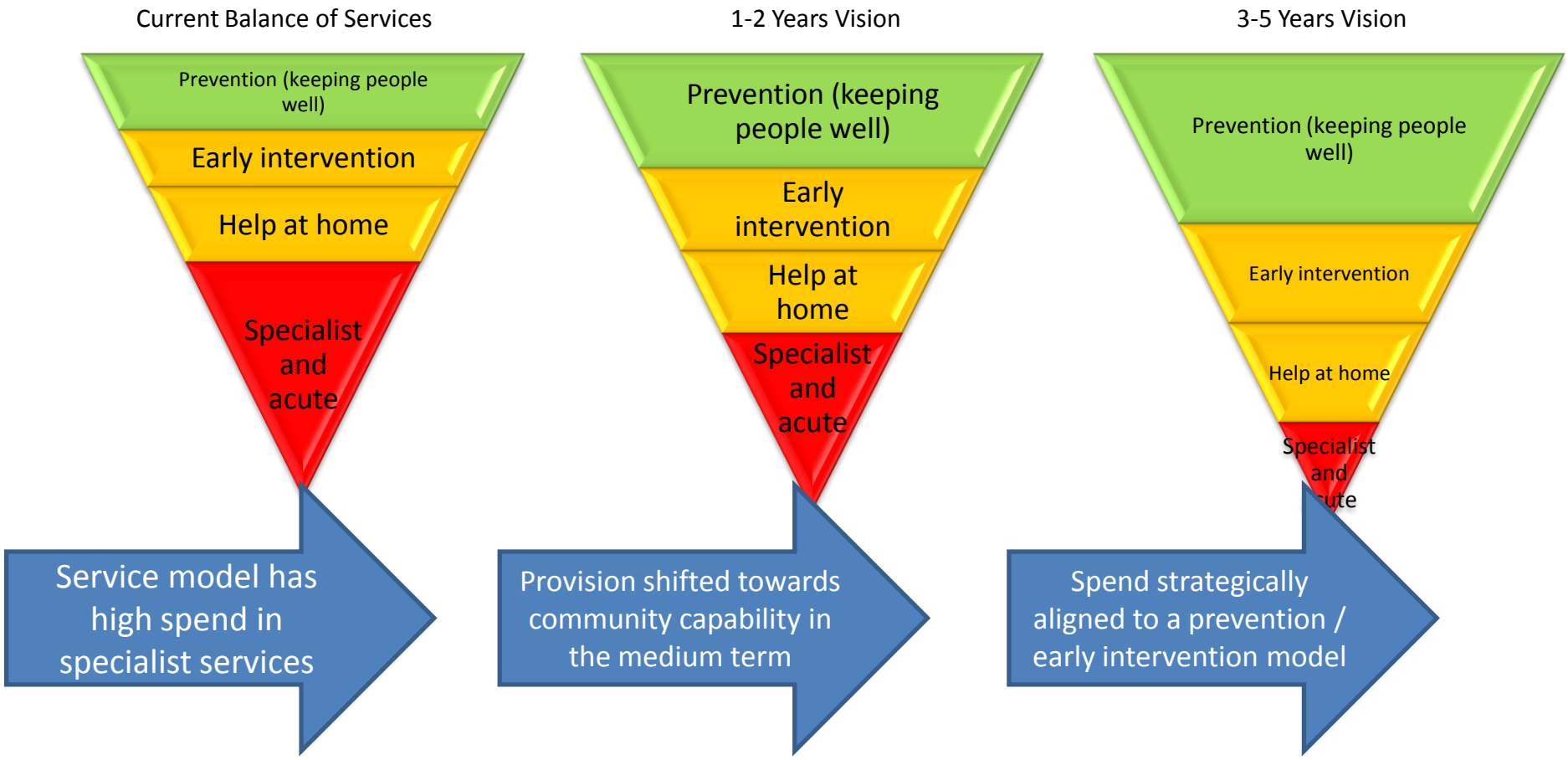
The system is driving the delivery of non complex elective care out of the hospital to deliver more care nearer to the home via primary and community care

Specialised services concentrated in centres of excellence

Whilst driving non-complex care away from the acute trust we will enable the repatriation of specialist interventions such as acute stroke and percutaneous coronary intervention (PCI Angiography)

1. Planning Guidance http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Vision for services – progress through Better Together Programme[1]



1 See also Better Care Fund Plan
http://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Better%20Care%20Fund%20plan.pdf

3. Improving Quality and Outcomes

Improving Quality and Outcomes

Introduction

National Planning Guidance requires CCGs to submit trajectories to support the seven outcome ambitions (see System Five Year Strategy):

- ✓ Securing additional years of life or people with treatable mental and physical health conditions
- ✓ Improving the quality of life of people with Long Term Conditions
- ✓ Reduce the amount of time spent avoidably in hospital
- ✓ Increasing the proportion of older people living independently at home following discharge from hospital
- ✓ Increasing the proportion of people with a positive experience of hospital care
- ✓ Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital
- ✓ Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

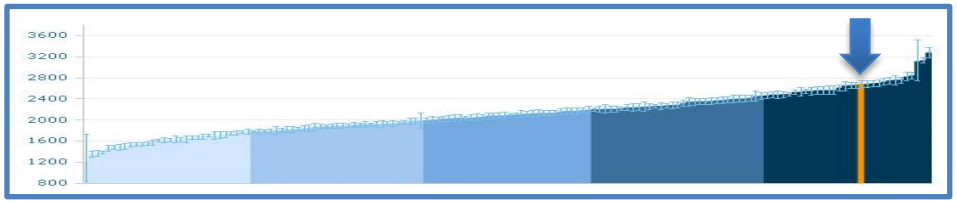
Process to Develop Outcome Ambitions

The initial proposals articulated in this document were developed by CCG Clinical Directors and Public Health utilising benchmarking data and in particular the performance of Luton in comparison to the national average and similar populations of Redbridge, Hillingdon, Wolverhampton and Birmingham East and North. The Levels of Ambition Tool enables benchmarking for the above outcomes and demonstrates that Luton outcomes are below the national average for many outcomes but is broadly performing in line with other populations with a similar make up to Luton.

Benchmarking Outcomes

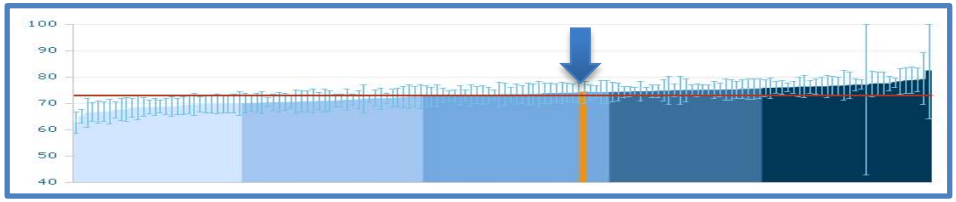
Potential Years of Life Lost

Luton Current Position: Baseline 2012 – 2669
Luton – Bottom Quintile



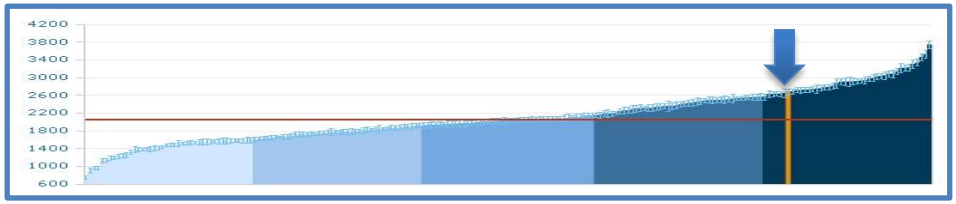
Quality of Life for people with LTCs

Luton Current Position: Baseline 2012/13 – 74.1
Luton – Middle Quintile slightly better than England



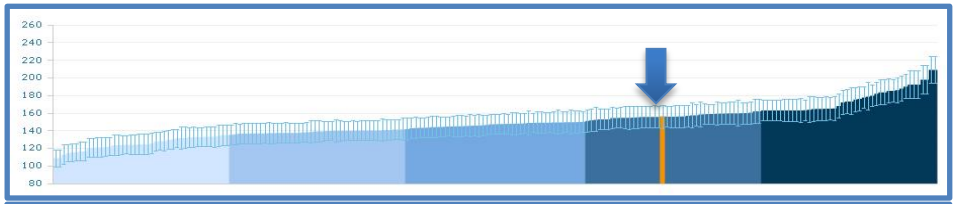
Avoidable Hospital Admissions

Luton Current Position: Baseline 2012/13 – 2668
Luton – Bottom Quintile



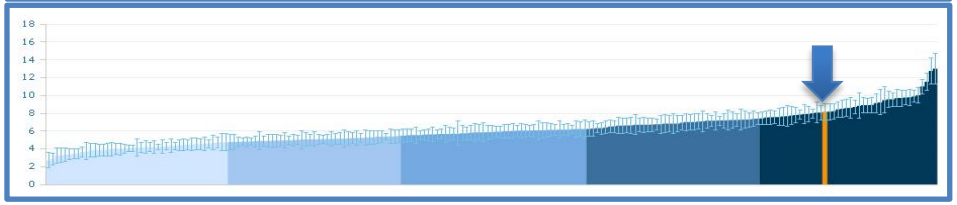
Patient experience in hospital

Luton Current Position: Baseline 2012 – 155
Luton – Quintile 4



Patient experience out of hospital

Luton Current Position: Baseline 2012 – 8.1
Luton – Bottom Quintile

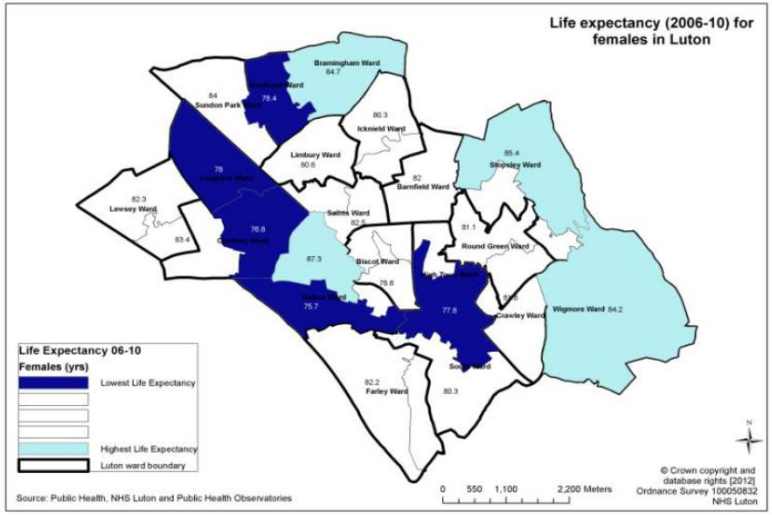


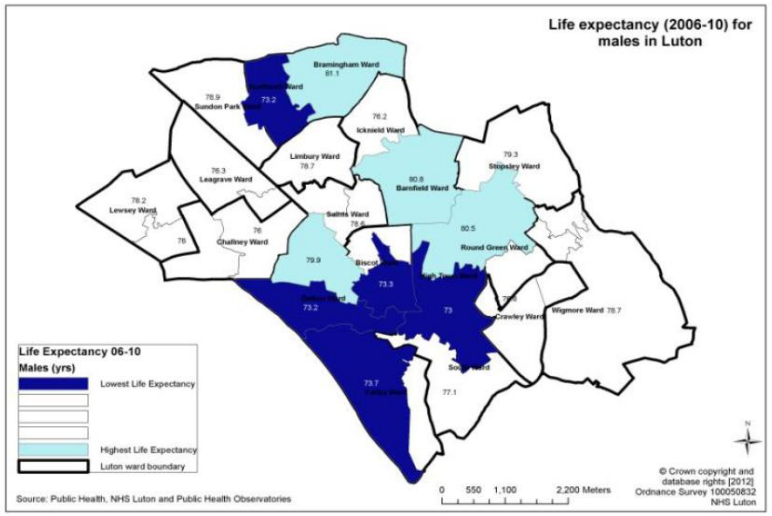
Health Inequalities in Luton

Research into the health of local people published in the Joint Strategic Needs Assessment (JSNA), in 2011, clearly identifies the key health challenges and highlights the inequalities in life expectancy which exist in Luton.

Although life expectancy in Luton has shown a steady increase since 1999, average life expectancy for both males (now 77.9 years) and females (at 81.9 years) remains below the national averages which are 79.2 years and 83.0 years respectively.

However significantly more worrying, these statistics mask the very serious inequalities that exist between areas within Luton with an 8.9 years life expectancy gap for males and 6.4 years for females between the most and least deprived areas of the town (see maps opposite).





Driving a Reduction in Health Inequalities

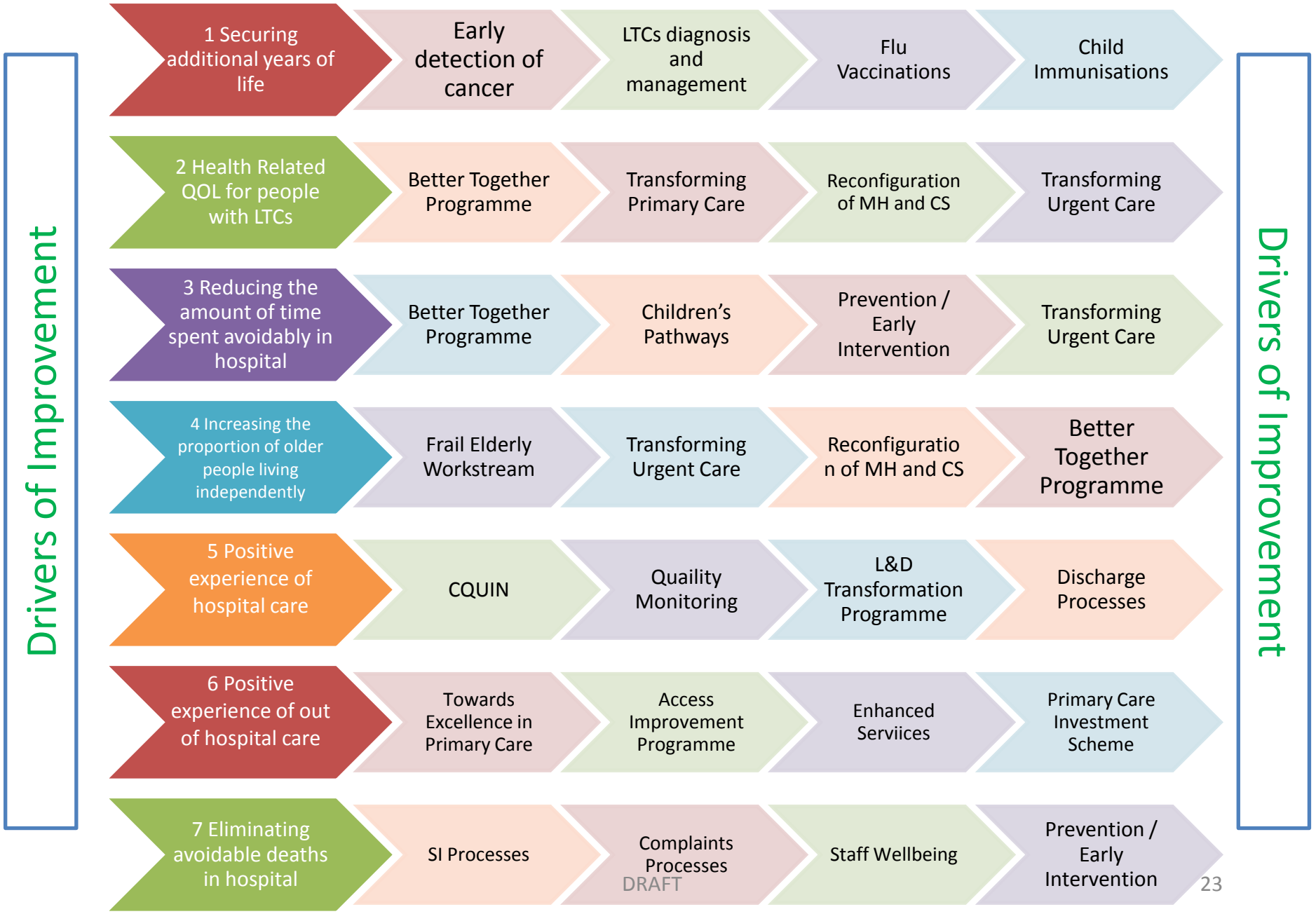
As discussed earlier in this document , the Luton Health and Wellbeing Strategy articulates 3 major priority outcomes goals: **1. EVERY CHILD AND YOUNG PERSON HAS A HEALTHY START IN LIFE, 2. REDUCED HEALTH INEQUALITIES IN LUTON** and **3.HEALTHIER AND MORE INDEPENDENT ADULTS AND OLDER PEOPLE.** The Children and young people's plan has been put in place to address Goal 1 and part of Goal 2. This Strategy addresses Goal 3 and part of Goal 2 and therefore implementation of this Five Year Strategy has a major role to play in driving a reduction in health inequalities through the following recommendations from the Health and Wellbeing Strategy

- Systematic programmes to reduce the variability of General Practice in Luton to ensure that all members of the Luton population are able to easily access high quality and safe primary care.
- A risk based approach to identify all patients on their lists with long term conditions who are at increased risk of exacerbation or admission and take proactive steps to ensure these patients are supported to minimise unnecessary admissions to hospital or complications.
- integration of health and social care services to improve health outcomes and seamless support to the individual
- Integrated wellness service

Seven Outcome Ambitions: 5 Years

1 Securing additional years of life	• Improve by 19% from baseline • 2669 (2012) to x 2194
2 Health Related QOL for people with LTCs	• Improve by 6% from baseline • 74.1 (2012/13) to 80 2018/19
3 Reducing the amount of time spent avoidably in hospital	• Hold at current position of 2668
4 Increasing the proportion of older people living independently at home following discharge	• There is no indicator currently available
5 Positive experience of hospital care	• Improve by 6% from baseline • Poor responses 155 2012/13 to 146 2018/19
6 Positive experience of out of hospital care	• Improve by 10% from baseline • Poor responses 8.1 2012/13 to 7.1 2018/19
7 Eliminating avoidable deaths in hospital	• There is no indicator currently available

3. Improving Quality and Outcomes



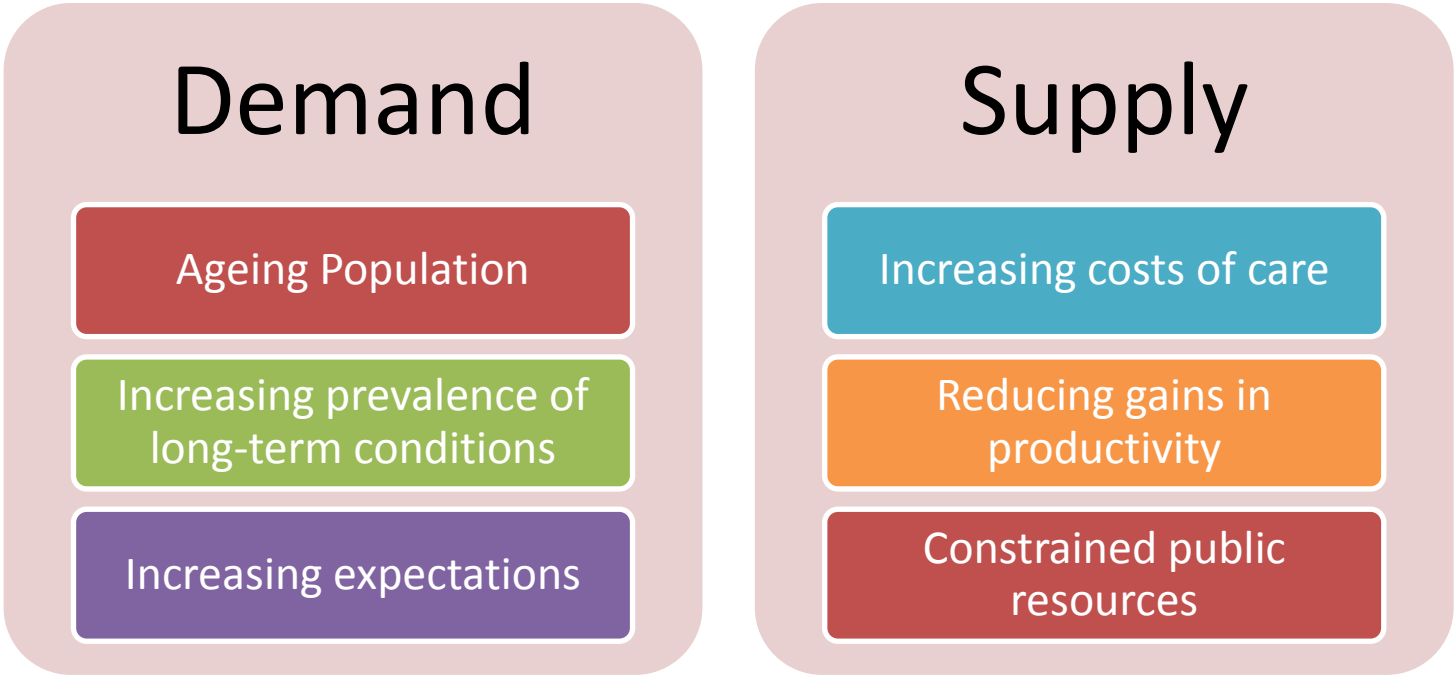
Additional (Local) Outcome Ambitions: 5 Years

Reduction in Infant Mortality Rate (per 1,000 live births)	• Baseline 7.2 (2009-11) • Reduce to 5.0 by 2017-18
Increased life expectancy at birth and narrowed inequality gap with England - Males	• Baseline 77.9 (2009-11) • Increase to 80.3 by 2017-18
Increased life expectancy at birth and narrowed inequality gap with England - Females	• Baseline 81.9 (2009-11) • Increase to 82.7 by 2017-18
Life Expectancy gap between the most and least deprived areas in Luton - Males	• Baseline 8.9 (2006–10) • Reduce to 7.9 by 2017-18
Life Expectancy gap between the most and least deprived areas in Luton - Females	• Baseline 6.4 (2006-10) • Reduce to 5.6 by 2017-18
Disability Free Life Expectancy (DFLE) - Males	• Baseline 9.1 (2011-12) • Increase to 10.0 by 2017-18
Disability Free Life Expectancy (DFLE) - Females	• Baseline 9.9 (2011-12) • Increase to 10.9 by 2017-18

Note : Needs to be updated to reflect 18/19 target

4. Sustainability

The Sustainability Challenge

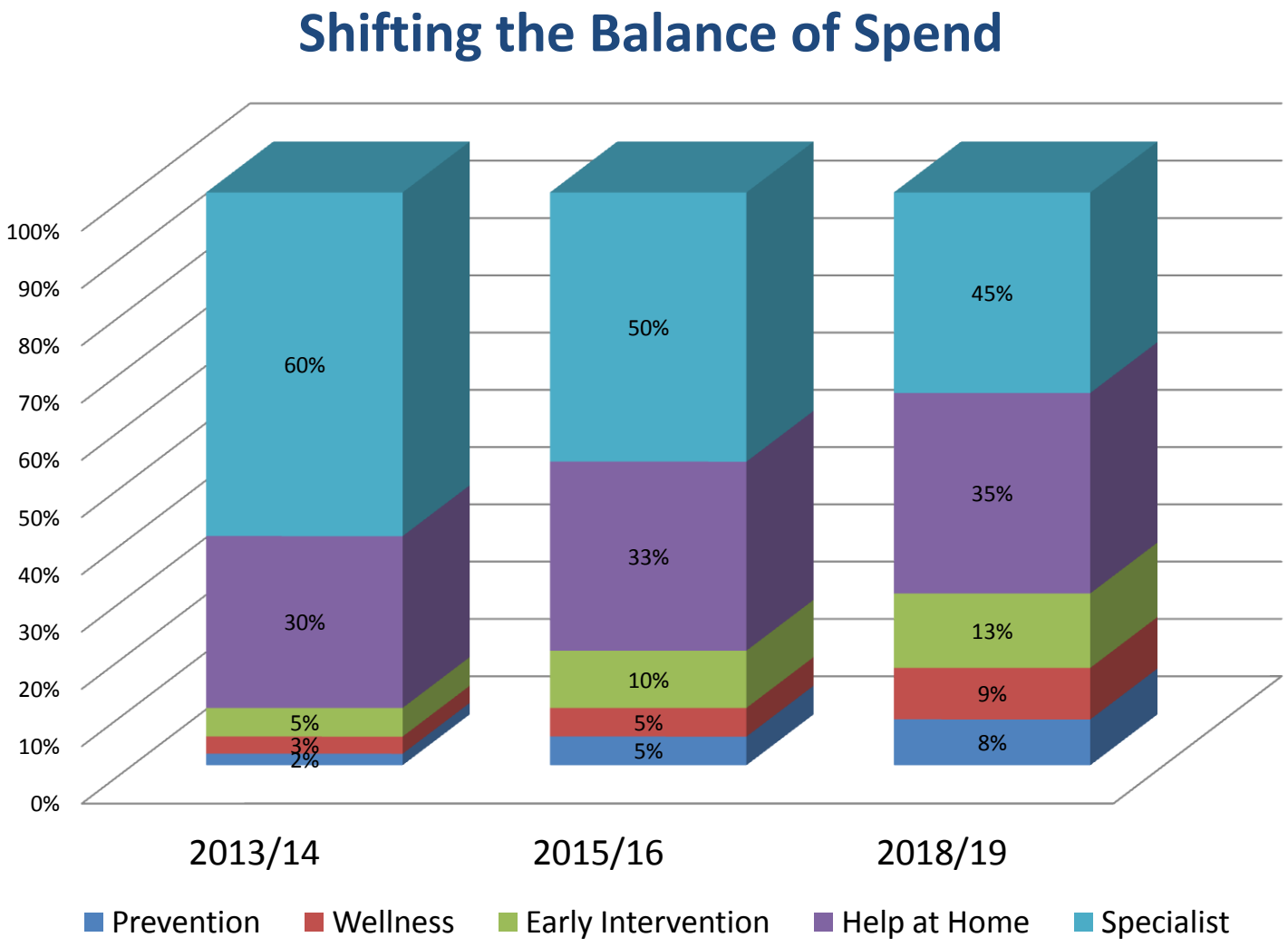


NHS England's "A Call for Action[1]" describes the future trends which threaten the sustainability of a high quality NHS. It is the potential impact of these trends summarised in the diagram above that means that while a new approach is urgently needed, we must take a longer-term view when developing it. The Luton system understands that in order to overcome the impact of these trends, we need to shift the balance of health and social care spend away from specialist care and towards prevention, wellness, early intervention and care at home so that specialist care is reserved for more complex interventions for the more severely ill.

[1] http://www.nhs.uk/NHSEngland/thenhs/about/Documents/nhs-belongs-to-the-people-call-to-action.pdf

Meeting the sustainability challenge

This graph is a stylised representation of the relative shift in the balance of spend, primarily driven by the Better Together Programme



Goals for sustainability

- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system outcome ambitions
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

5. Improvement Interventions

Summary of Key Interventions

Better Together – Integration of Health and Social Care

- Building personalised services around the needs of patients
- Switching the focus towards prevention and early intervention

Transforming Primary Care

- Driving a transformation in the capacity and capability of primary care to deliver a broader range of high quality and safe services in the community.

Reconfiguring Mental Health and Community Services

- Redesign of community and mental health services to drive improved health outcomes, system integration and financial sustainability

Transforming Urgent Care

- Redesign of unscheduled care provision to ensure the right level of care delivered appropriate to the needs of the patient.

5. Improvement Interventions

Better Together[1]

Frail Elderly. Personal e-plans, shared across the system delivering seven days a week service coordinated around the needs of the patient

Disabled Children. Holistic assessment of educational, social care and health needs met through the delivery of a single plan

Information Sharing. A single e-plan accessible via mobile devices to provide access to critical information by all involved in the delivery of care

Shared Services. A collective approach to procurement and back office functions

Organisational Change. Delivering the shift from individual organisation vision and purpose to a collective vision and purpose

Seven Day Working. For health and care services preventing unnecessary hospital stays and maximising service user and patients' independence

Homecare Plus. Implementation of multi-tasking Homecare Plus workers to keep people safe at home and maximise independence

1 See also Better Care Fund Plan
http://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Better%20Care%20Fund%20plan.pdf

5. Improvement Interventions

Transforming Primary Care

Towards Excellence. Clinically led practice development programme driving reductions in performance variation in clinical quality, safety and financial performance across practices

Primary Care Access Improvement. Focused CCG-led support programme driving improvements in practices in the bottom decile based on the GP Patient Survey

Primary Care Investment Scheme. Driving the achievement of local priorities, making funds available to deliver high quality primary care at scale

Workforce Development. The CCG is implementing its Organisational Development Plan which includes the development of primary care clinicians and attracting primary care leadership talent to the area

A key enabler of transforming primary care is our plan to formalise the establishment of 4 Practice Groups (oe "Clusters" covering populations of 25,000 – 60,000. Each group will be chaired by a GP and supported by a co-ordinator with CCG approved governance arrangements in place to drive innovation, value for money, improved outcomes by enabling:

- Practices to work together to bid for and provide services at scale
- The sharing of premises and back office functions to allow system wide efficiencies
- Increased local workforce development opportunities
- Development of shared ICT and implementation of new technologies

Further details can be found in the CCG Operational Plan 2014/15 – 2015/16[1]

1 https://www.lutonccg.nhs.uk/page/downloadFile.php?id=12566

Reconfiguring Mental Health and Community Services

Prevention and Early Intervention. Delivering a cost-effective impact "downstream", helping people to recover more quickly from illness and maximising independence for those with long term conditions

Integration and Collaboration. Driving system collaboration and an approach embedded in the principle "the needs of patients are more important than the needs of the organisation"

Workforce. Attracting the right talent to Luton and establishing a world class workforce which places patients at the heart of all we do

New Pathways of Care and Innovation. Driving innovative services build around patients with GPs as the central point within an integrated model

Value for Money. Effective use of resources across the health, social care and other public services in Luton

Patient Engagement and Experience. Using service user and carer feedback to develop effective services for vulnerable adults in the past ensuring equity of service and a seamless care experience.

5. Improvement Interventions

Transforming Urgent Care

111. Driving improved signposting to the right services to meet the individual needs, reducing pressure on A&E attendances and short stay admissions.

Hospital at Home. Supporting early discharge through a Hospital-at-Home nursing team under the direction of the consultant.

Acute Home Visiting Service. Supporting General Practice by undertaking home visits to patients early in the day, addressing care needs in the home.

Ambulatory Care. Patients attending A&E who are mobile are streamed early to a dedicated service which can provide speedy resolution of care needs, and discharge patient, with follow-up as required.

Ambulance Response – Care at Home. Ambulance paramedics supporting people at home where appropriate

Clinical Navigation. Clinical Navigator Nurse Team providing holistic direction to patients being discharged from A&E and EAU to ensure that appropriate follow up care is in place

Intervention Outcomes

Better Together

- Shift of spend towards prevention, early intervention, and care closer to the home.
- Securing additional years of life; increasing QoL for LTCS; Reducing unnecessary hospitalisation; independent living

Transforming Primary Care

- Delivery of range of low complexity "acute" services in the community; Reduced variation in primary care outcomes; enhanced patient experience; reduced unnecessary admissions to hospital

Reconfiguring Mental Health and Community Services

- Integration of mental health and community services; Securing additional years of life, QoL for people with LTCs, reduced unnecessary admissions, improved post-discharge outcomes, improved patient experience

Transforming Urgent Care

- Supporting the integration of health and social care; reduced unnecessary admissions to hospital; reduced demand on A&E; improving experience of out of hospital care.

6. Citizen and System Engagement

Citizen Engagement

The heart of integrated health and social care is person centred planning and this plan draws on a wide range of national and local evidence and experience to set its principles around resident engagement and the importance of listening and responding to the real life stories that tell local residents' experiences.
Our goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient
partnership – in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety.

Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking, "What's the matter?" to, "What matters to you?" This will require the system to learn and practice partnering with patients, and to help patients acquire the skills to do so

In order to ensure that Luton residents' views are taken into account, LBC has developed six principles for public consultation:

- Community involvement should be at the heart of how partners improve services, set priorities and use resources.
- There should be a range of opportunities for involvement that are well publicised, link to local democracy and in which all citizens are encouraged to participate.
- Methods for involvement should be regularly reviewed to ensure they are cost effective, and meet the preferences and needs of all citizens
- Citizens should receive clear and prompt feedback on how their involvement has helped to shape services, places and communities.
- Partners should work in a joined up way to avoid duplication.
- Involvement should be the basis on which partners increase satisfaction, build trust and confidence in their organisations.

[Community Involvement Strategy. LBC, 2010]

Citizen Engagement "Your Say, Your Way"

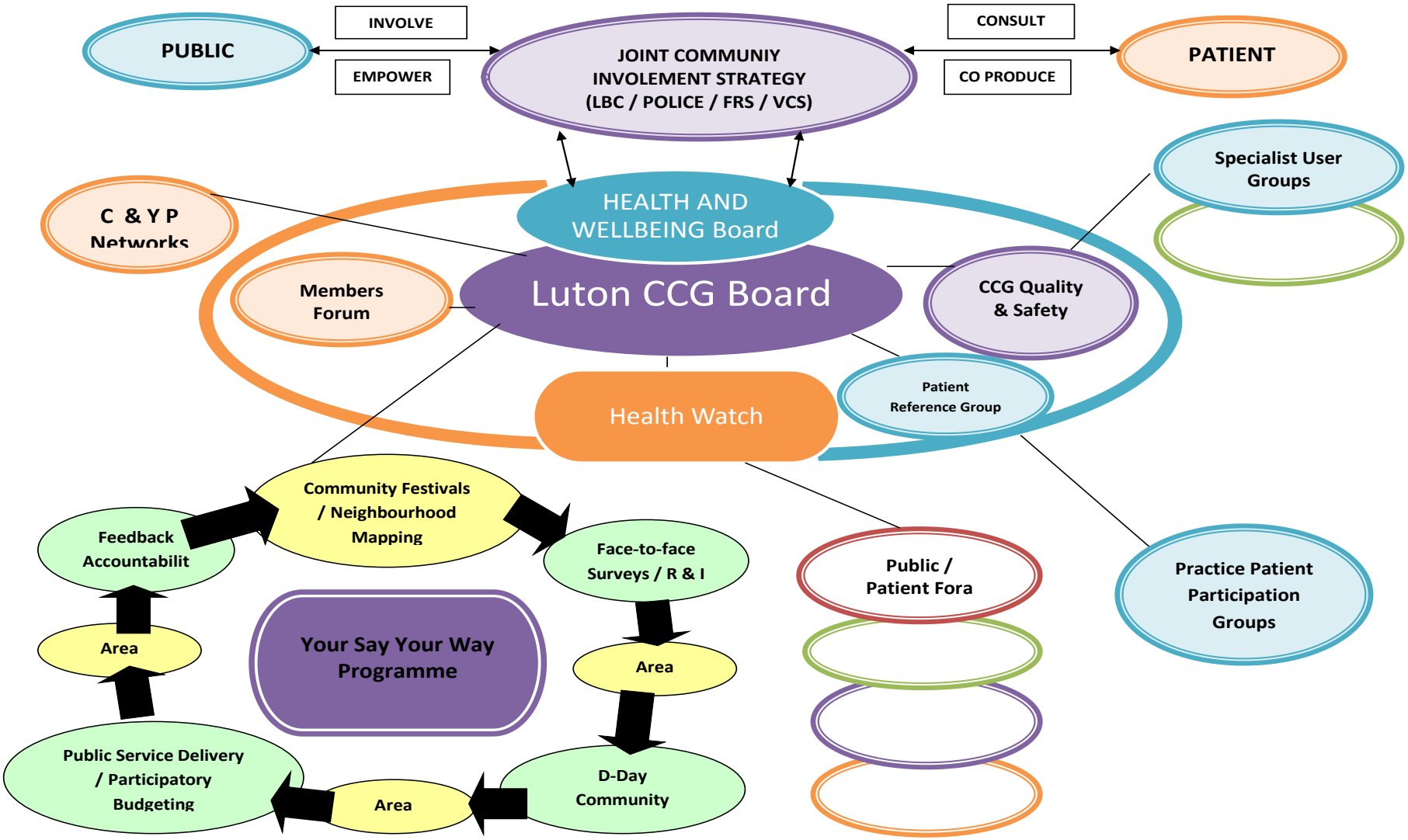
LBC and LCCG are active members of the "your say, your way" programme which enables a robust feedback cycle between community concerns and system response to those concerns.

The programme delivers a range of community involvement, development and grant funding opportunities which are adapted to identify the priorities for and meet the needs of each neighbourhood, including:

- Community festivals
- Neighbourhood mapping/Community surveys (R&I)
- Local neighbourhood networks
- Area Board partnership work programmes and reporting arrangements
- Participatory budgeting/ community project support
- Volunteer development and community learning opportunities
- Community planning decision days

These platforms provide unique opportunities for reaching large numbers of local people for the purposes of public information and health promotion, community empowerment, consultation, accountability and direct local involvement. Diversity profiling of community involvement in the programme consistently shows significant increases and improvements in community involvement matching the diversity of local populations – in other words, the programme makes a major contribution to social inclusion reaching communities that much conventional public engagement does not.. Although the programme now provides coverage across the Borough, it continues to maintain a focus on neighbourhoods and LSOAs with relatively higher levels of deprivation and health inequalities.

Luton Engagement Map



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Clinical Engagement

General Practice

Clinical Commissioning places GPs and other Clinicians at the heart of commissioning. The CCG has a well developed programme of on-going communication channels for practice engagement such as practice visits, the Members Forum, Practice Managers Group and Protected Learning Time. As a result almost 40% of our local GPs are actively involved in leadership roles in the CCG.

Wider Clinical Engagement

The development of this strategy has also been strongly informed by the views of clinicians working outside of the GP Community. A programme of clinical engagement has been delivered via the following routes

- ✓ Luton and Dunstable Hospital "Grand Round"
- ✓ Clinical Engagement Suppers
- ✓ Board to Board meetings with key providers
- ✓ CCG Clinical Commissioning Committee – which includes members from Community Pharmacy, Optometry and Dentistry
- ✓ Integrated Diabetes Local Implementation Group
- ✓ Respiratory Local Implementation Group

The system is currently also putting in place a formalised Clinicians Forum comprising members from L&D Hospital and Luton, Bedfordshire and Hertfordshire CCGs

Engagement Objectives

1. Further develop a patient and community engagement model for Luton which is underpinned by a transparent and inclusive governance infrastructure which will ensure that patients, the public and partners are actively engaged with and feel they can influence commissioning decisions to improve local health and social care services

2. Ensure that every Luton General Practice has an active Patient Participation Group in place which is able to ensure a feedback loop is in place to drive improved commissioning decision-making

3. Provide all staff with the tools and knowledge to ensure that patient and community engagement is at the heart of commissioning and service provision

4. Drive behavioural changes in the general public to ensure that they understand the need to act in order to a) Maintain a healthy lifestyle b) Understand the importance of early intervention c) Access the right services to meet their needs when they are ill

5. Ensure full system-wide clinical engagement to ensure decision making is clinically-led and as effective as possible.

6. Ensure that “early-warning” systems are in place so that issues regarding quality and safety of services can be addressed immediately

7. Developing the Workforce

Workforce Transformation

The Luton System is developing 5 year workforce plan for Luton with key partners across the health and social care system including Heath Education East of England, Skills for Care, Skills for Health and the University of Bedfordshire. This takes into account the current difficulties in recruiting into Adult Community Nursing and Specialist Services.

In order to provide higher acuity care for adults older people and those with long term conditions , the community nursing and social care workforce will need to be enhanced both in terms of numbers and skills.

Forecasted workforce requirements are an integral part of the procurement process for Community health services and the Better Together integration programme for Luton

The CCG is implementing its Organisational Development Plan which includes the development of primary care clinicians and attracting primary care leadership talent to the area. A scheme is being developed by the CCG to recruit GPs into Luton, working with the GP Tutor, Health Education England and University of Bedfordshire. The scheme will take 2 GPs per year for a three year programme, with sessions in practices, the CCG and the University.

Seven Day Working

Nationally, NHS England board has committed the NHS to "move towards routine services being available seven days a week. This is essential to offer a much more patient-focused service and also offers the opportunity to improve clinical outcomes and reduce costs.

Our priority for the first two years of this strategy will be to extend services across the health and social care system where this will enable admission prevention, reduce the risk of emergency re-admission, speed up hospital discharge and ensure everyone can leave within 24 hours of being "ready to go"

A review of hospital discharge processes undertaken in 2013 identified a number of areas where improved access out of office hours would help us to deliver improved outcomes. These include:

- Adult social care services to work with residential / care homes to overcome barriers to receiving patients back at weekends and after 4.30pm
- Exploring the provision of a jointly resourced social work service with Central Bedfordshire to cover weekend work
- Integrated discharge team to work seven days to ensure that CHC assessments involve carers and families , supporting them to make early decisions on discharges
- Community nursing covers seven day working, the intermediate care services supported by social care will move to a similar pattern to support rapid assessment and early supported discharge for stroke patients back into the community and into rehabilitation services.

8. Governance

Proposed System Governance for Strategy Development and Delivery

9. Risk

Managing the Risks Associated with Strategy Delivery

The delivery of our strategy has been risk assessed and the top three risks[1] are listed below.

Risk	Risk Rating	Mitigating Actions
Alternatives to admitting and keeping people in hospital as a way of preventing unnecessary hospital stays may not be in place in time or at sufficient capacity to enable closure of two hospital wards.	High	Existing work to speed up discharge will continue and step-up and step-down capacity will be kept under close scrutiny, along with the development of greater home care service flexibility to ensure there are a number of routes available to avoid the need for unnecessary hospital stays.
We will not have the right whole system workforce (mix of skills location and practice).	High	Develop a total workforce strategy with help from Health Education East of England, Skills For Care, Skills For Health and the University of Bedfordshire. Scoping meeting set for 9 April and whole system project group led by director of housing and community living from Luton Council.
Luton residents, including patients, service users and carers, are insufficiently engaged in the planning process and the final plan fails to reflect community priorities	High	Consultation is already underway and a community engagement programme is being developed in conjunction with Luton Healthwatch.

1 See also Better Care Fund Plan
http://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Better%20Care%20Fund%20plan.pdf

10. Plan on a Page

In 2019 Luton residents will benefit from integrated health and care that has four elements: a person centred approach enabled by a shared personal plan for patients and service users; prevention that helps people to keep themselves well; better use of shared evidence and data; a multi-disciplinary, multi-professional team approach to service delivery built on three GP clusters in the town. We will work in partnership with patients, their carers, providers and other partners to deliver a high quality and cost effective health and social care system to the people of Luton, empowering them to lead healthy and independent lives.

System Objective One

To reduce potential years of life lost by 19%

System Objective Two

Increasing the proportion of older people living independently at home following discharge

System Objective Three

To improve the quality of life people with LTCs by 6%

System Objective Four

To stop the increase in unnecessary hospital admissions

System Objective Five

To increase patient experience of care outside of hospital by 10%

Delivered through Better Together Programme

Whole system integration programme

-driving the effective use of ***shared evidence*** and data -shifting the balance towards wellness (***prevention*** and early intervention)

-delivering ***personal plans*** to build the right services around the needs of individuals

-creating a ***multi-disciplinary team*** to deliver personalised care

Delivered through the Reconfiguration of Mental Health and Community Services: Redesign of community and mental health services to drive improved health outcomes, system integration and financial sustainability

Delivered through the Transformation of Urgent Care

Redesign of unscheduled care provision to ensure the right level of care delivered appropriate to the needs of the patient.

- NHS 111
- Hospital at home
- Acute visiting service
- Clinical Navigation
- Ambulatory Care

Delivered through The Transformation of Primary Care : Driving a transformation in the capacity and capability of primary care to deliver a broader range of high quality and safe services in the community.

Overseen through the following governance arrangements

- Health and Wellbeing Board and Healthier Luton Partnership overseeing implementation of the improvement interventions
- Individual organisations leading on specific projects

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

Our System Principles

- Integration and collaboration
- Service Innovation
- Services around the patient
- Safeguarding the vulnerable
- Early intervention
- Value for money
- Citizen engagement
- Quality and Safety